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Further Reflections on the Impact of Clinical Writing on Patients

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Though it is unlikely that instituting universal guidelines will ever be possible for patient approval of the analyst's use of clinical material outside of the treatment setting, the author offers some supplementary reflections to those already available in the literature. Broadly applied informed consent guidelines would increase the distortion that already exists in our clinical literature due to self-imposed restraints by writers. Moreover, the powerful irrational forces mobilized by consent in the dyad are not easily 'held' by traditional applicable legal categories. Metapsychological formulations of the intrapsychic and intersubjective impact of patient participation in the writing process on individual analytic dyads are needed. Notions of privacy protection, validation, dyadic co-construction, or writing-as-containment by a third as rationales for informed consent fail to encompass the transindividual and external sources of human identity and the ineradicable lack of unity in the unconscious. Nevertheless, theoretical affinity and preferred technique may be mediating factors in positive outcomes of the consent process. Some paradigms not only accommodate more comfortably but also actively seek the intersubjective repercussions of informed consent. As an alternative or complementary viewpoint, the author offers the hypothesis that the clinical ramifications of either disguise or consent are not exclusively, nor even necessarily, concerned with what patients read about themselves, but what they assess or intuit—directly or indirectly through the material presented—of their analyst's unconscious strivings. To truly triangulate the clinical reporting project, it is wisest to consult the third ear of a colleague to assess the potential impact on patients on what might be being unconsciously transmitted by the analyst in the writing and the consent process.

Introduction

The growing pressure for informed consent in clinical writing from lawyers, ethicists, and from analysts who argue for the clinical merits of consulting their patients continues to raise concerns for many in our field, despite the accumulation of strong arguments over the years in favor of it. Elsewhere (Furlong, **1998**, **2005**), I have marshaled theoretical arguments against a universal policy of informed consent in psychoanalytic writing. Since some disguise usually accompanies the clinical account whether or not the patient is consulted about it, the choice is actually between disguise with or without patient permission. An independent reviewer of an earlier draft of this paper pointed out, however, that reservations about climbing on a bandwagon of informed consent skirt to some extent the larger problematic of the complex impact *in either case* on patients of reading, or hearing, about themselves

in scientific presentations and publications by their analysts. The clinician is always faced with the need for an assessment, to the best of his ability, of the potential impact on the patient of the clinical material. I would argue that this assessment should not be pre-empted by other ethical or legal premises.

Ideally, the decision on whether to seek patient consent should be guided by metapsychological reflection and not solely by the imagined manifest content of the patient's reactions. What happens in the intersubjective space of the dyad when a request for publication is made? What might happen if the patient discovers the paper when he or she has not been consulted about it? What communalities and individual variations exist? Until very recently, there were few illustrations in the literature detailing the impact on ongoing analytic work of patient involvement in the presentation or publication process (see for example, **Stein, 1988b**; **Stoller, 1988**; **Lipton, 1991**). We must be grateful, therefore, for the appearance in the last five years of at least two review articles (**Gabbard, 2000b**; **Galatzer-Levy, 2003**) and of a number of contributions detailing transference and countertransference spin-offs in individual treatments (**Crastnopol, 1999**; **Aron, 2000**; **Pizer, 2000**; **Scharff, 2000**; **Stein, 2000**; **Tuckett [internet]**; **Brendel, 2003**; **Carter, 2003**; **Halpern, 2003**; **Joffe, 2003**; Kantrowitz, **2004a**, **2004b**, **2004c**, **2005a**, **2005b**, **2005c**, **in press**; **Brenner, 2005**). This emerging literature reveals the deep concern of authors to avoid wounding their patients and the search for meaningful ways to anticipate and comprehend patient reactions, positive and negative. Analysts' guilt about their writing is possibly an additional and poorly understood mediating variable in outcome, a point I take up later. Numerous vignettes show that a sensitive clinician can negotiate patient participation in the analyst's writing prior to publication (or work through with the patient the impact of self-recognition after publication) to the 'therapeutic' benefit of both parties. Having made the plunge to consult their patients, these analysts were persuaded that the ensuing trial of fire led to a deepening and strengthening of the analytic process. Despite these positive findings, informed consent is far from foolproof in preventing patient distress (**Stein, 1988b**; **Stoller, 1988**; **Brendel, 2003**; **Carter, 2003**; Kantrowitz, **2004b**, **2005a**, **in press**) and the working through of the transference and countertransference repercussions can take a long time, sometimes years. An unexpected revelation contained in Kantrowitz's ongoing research **(in press)** is that some patients who were consulted about clinical material were bothered by details of the disguise itself, interpreting it as a hidden or unconscious attitude in the analyst!

In this paper, I present a critique of several current approaches to thinking about the impact of clinical writing on patients, which, I argue, have limited ethical/theoretical relevance and coherence. The alternative model I propose for conceptualizing this impact does not, unfortunately, provide the basis for a universal guideline—which most experts agree is impossible—but at least promises a metapsychological way of reflecting on it that is theoretically coherent and consistent with reported clinical complexities.

The Restrictive Impact of Patient Access on Psychoanalytic Literature

It is yet another instance of the specificity of our work that broadly applied informed consent guidelines would have a far more radical effect on our scientific

publications than on those in other fields. Any claim of psychoanalytic clinical writing to scientific discourse would be discredited. In her research on the question of consent in clinical writing, Kantrowitz (**2004a**, p. **90**) held that there is 'likely to be some skewing of what is presented in the literature' if analysts cannot write or present without permission from patients. Imagining a future of widespread patient vetting of psychoanalytic case studies, Levin concludes: 'to paraphrase a current political cliché, we will have evolved a body of clinical work that is "intersubjectively correct" but of limited use for the transmission and advancement of psychoanalytic knowledge' (**2003**, p. 67).

In fact, however, an equally remarkable 'unthought known' **(Bollas, 1987)** emerges from Kantrowitz's work. Her interviews confirm that many analysts refrain from writing about patients for reasons related to the sensitiveness of the topic or to the anticipated transference reaction. *What this current data force us to conclude is that the contemporary analytic clinical literature may already be largely unrepresentative of day-to-day analytic work.* The intersubjective factors restricting the analyst's decision about whom to write and what to write about and when may have created a situation that fetters our discipline with a vast system of skewed patient selection and spontaneous professional self-censorship. It is quite possible that our literature has never been particularly indicative of the actual variance of psychoanalytical technique and framework to be found in clinical practice. In a fairly recent article on the case history, **Michels (2000)** noted that already, over 25 years ago, Anna Freud was drawing attention to the conspicuous dearth of complete and adequately documented case histories. Michels views this disproportion between theory and clinical data in the psychoanalytic literature as 'strikingly unbalanced' (p. 355). In another study, Klumpner and Frank concluded that the 'dearth of clinical data was characteristic of the psychoanalytic literature as a whole' (**1991**, p. **538**).

Unfortunately, then, the requirement of universal informed consent would intensify an already lopsided state of clinical reporting. Though our discipline is perhaps not uniquely weak on this measure of scientific method—reservations about the neutrality of privately funded pharmaceutical research might approach the same scale—it is a sobering speculation. Repeatedly, Kantrowitz's interviewees mention reason after reason (the list is too long to include here) for not writing up cases. Essentially, there may be an overrepresentation in the psychoanalytic literature of vignettes in which the patient feels adequately mirrored and reassured, as well as the tendency to publish work that the analyst can reasonably count on escaping 'patient detection.'

Problems With the Approaches of Privacy, Co-Construction, and Ownership

None of the usual legal or ethical approaches to this issue comes close to solving the intersubjective boomerang effects caused by patients' encounters with the portrait of themselves conveyed in clinical writing. Some mishaps—such as when the analyst did not foresee that their request would stir up conflict, or when patients felt betrayed, resentful or excited about requests for consent, or when inadvertent

self-recognition happened after consent was not obtained—are attributed to fallout from the breach of patient privacy or from the analyst's 'misappropriation' of the patient's 'ownership' of the clinical narrative. Yet in many situations these explanations fall short: for example, patients who show strong negative feelings even when disguise makes recognition impossible for anyone other than themselves. One of Stoller's patients expressed it vehemently: '[Y]ou were transgressing that sacred boundary, the infinite trust I placed in you. Why did it matter so? It was true, [and] *no one else knew*' (**1988**, p. **382**, my italics). Though at least two former patients in Kantrowitz's sample were offended to the point of launching suits contesting use of their material without consent, the court concluded in both instances that disguise was adequate and that the patient had suffered no 'harm.' In these particular instances, if recognition by others is not the boundary that has been transgressed, then patient pain cannot be explained as loss of privacy but more as a breach of trust about the conditions of disclosure. The 'betrayal' is not so much of 'privacy' as of an intimate 'sacred boundary.'

The insufficiency of contemporary judicial and ethical categories to encompass these variations in patient reactions is further illustrated by the phenomenon of patients 'recognizing' themselves in clinical material penned (consciously) by the analyst about someone else. Since false recognition is unpredictable and based on universal longings for special status, it does not seem realistic to hope that legal and regulatory sources of guidance or remedy can replace the only adequate tool in such cases: the psychoanalytic work itself. These experiences reveal the blurring of public/private boundaries in psychoanalytic treatment. Legal methods of defining harm to the patient are of limited use in assessing or in preventing unexpected sentiments of betrayal in many patients because these methods are not designed to account for either the irrationality and intersubjectivity of the unconscious or for the primordially external and transindividual sources of human identity in primary caretakers, extended family, social class, ethnic group, and the wider culture.

Or rather as Mauger has argued, as long as individual privacy remains the only focus of confidentiality, we avoid confronting that also at stake is 'unconscious transindividual content, of which we are equally the keepers' (**2003**, p. 59). The public/private boundary is not so much blurred as pierced by our trade with the unconscious. Mauger puts it this way: 'It is rather a "return to sender" of information that by its nature transcends individual existence, passing through it, leaving deposits, even burrowing within the inevitable transference repetitions' (p. 58). The need to publicly reveal something of this transindividual unconscious may thereby, according to Mauger, 'in some cases, unavoidably take the form of an individual "breach of confidence"' (p. 59).

Theorizing the clinical implications of the transindividual aspects of the human psyche has been a concern of intersubjectivists and self-psychologists like **Stolorow and Atwood (1997)** and **Goldberg (2004a)**. Stolorow and Atwood insist 'that all human experience is embedded in constitutive relational systems' (**1977**, p. 439). Independently, Ogden also muses upon the transindividual character of 'truth' in the analytic process: 'It seems that paradoxically what is true

is timeless, placeless, and larger than any individual, and yet alive only for an instant and unique to the set of circumstances constituting that moment of lived experience by one person' (**2003**, p. 599). Ogden places himself in accord with those like Bion who claim there are truths that pre-exist and are 'independent of the thinking of any individual thinker' (p. 596). Despite the separate theoretical points of reference of these different authors, they converge in stressing the 'unbearable embeddedness of being' (Stolorow and Atwood, **1997**, p. **439**). Like genetic heritage, therefore, large chunks of the defining coordinates and structure of central emotional complexes are 'passed on.' From this perspective, though the constructions of analysis resituate the patient as lead character in his life, does this 'reinscription' which integrates and subjectifies his experience justify his authorial copyright?

If not strictly speaking the individual's, then whose case history is it, one might ask. Do we reply like Ulysses to the Cyclops, 'No one!?' Few analysts today would dispute that analyzability, analytic process, and transference patterns are joint products of an inextricable intertwining of the relative contributions of the personality and unconscious conflicts. What may become debatable are the technical implications to be drawn from this full 'two-person' perspective when applied to the ethics of clinical reporting. Some analysts feel that it is wrong not to request the patient's permission because they believe that the 'co-constructed' narrative partially 'belongs' to the patient. In Goldberg's (2004b) recent grappling with the confidentiality conundrum, he has tried to tease apart the 'ownership' of the psychic material produced by the analytic dyad. He considers the proposal of an imaginary axis that distributes property rights from those belonging exclusively to the patient (such as the narrative of her history and the narrative within the analysis) to those considered co-products of both members of the dyad, to the opposite extreme of those belonging to the analyst (such as her formulations, interpretations, and countertransference) (p. 519). This thought experiment of respective territories in the dyadic experience might eventually make legal sense but it is one that is denied by everyday clinical experience and the intricacies of human development. The grandiose irrepressibility of unconscious desire and identification does not abide by conscious separations of self and other. Not only can patients be wounded by what they learn of the analyst's countertransference that strictly speaking does not belong to them, their own psychic productions, though indubitably 'theirs,' are often accompanied by a sentiment of 'strangeness,' of the *unheimlich*, disowned by the ego.

Our personal story is to a large extent only ours because it 'happened' to us, not because we initiated or controlled its more dramatic moments. The notions of 'ownership' or 'theft of narrative' **(Sundelson, 2003)** in such circumstances might be viewed as a narcissistic illusion in the service of the pretensions of the ego. Far from being under the influence of man, civilization and family make their impact on man from a point outside, foreign, and uncanny to him, in the same manner as the unconscious does from within, also uncannily other **(Imbeault, 1994)**. Might the idea of ownership of one's 'self,' while ethically and legally necessary in day-to-day life, appear in the consulting room to correspond to what Stolorow and Atwood have called the 'myth of the isolated mind … a form of defensive grandiosity' (**1997**,

p. 439)?[1] In seeking an ethical solution to the confidentiality issue in a sophisticated delineation of ownership, Goldberg seems to contradict the invitation he expresses elsewhere to 'think of mind more as a form of activity than primarily as a location' (**2004a**, p. 133). So how can we approach the technical and ethical challenge of confidentiality when we avow the necessity of a 'trans-personed' perspective?

Other rationales for informed consent: Patient participation in writing as validation, reassurance, co-construction, and containment by a third

In a recent critique of relational psychoanalysis, Jon Mills remarks, 'relational analysts are commendably brave to report case studies where their own internal processes and intimate experiences are discussed openly in professional space, which I find of great service to the community because it breaks down oppressive taboos' (**2005**, p. 178). Because of the generous sharing of their clinical work, we can examine for ourselves (to the limited extent possible for a reader) three representative claims (**Crastnopol, 1999**; **Gerson, 2000**; **Pizer, 2000**) about the therapeutic advantages of informed consent.[2] Pizer has written several times about the impact of his clinical writing on treatment and relates two treatments that in his estimation 'benefited dramatically from being written about' (**2000**, p. 207). Though I am inclined to believe him, there are indications that his results would not be generalizable. In fact, Pizer explicitly eschews a 'once-and-for-all-answer' (p. 258) that would apply to every dyad. Pizer explains his analytic style as valuing the goal of being able to 'relate more collegially' with his patients and of being able to move to a 'common ground' (p. 253). In the two cases referred to, both he and his patients seemed to agree that the main source of patient difficulties stemmed from childhood deprivation and/or abuse and, consequently, on the need for a 'healing relationship' in the form of the analyst's acting as a good enough symbolic parental substitute. Pizer writes of the therapist offering this kind of patient 'elemental features of his or her presence—containment, acceptance, and recognition' (p. 256).

A reasonable working hypothesis with regard to the category of psychoanalytic experience reported by Pizer (i.e. patients with deficits, object hunger, and strong positive transference combined with an analytic style stressing mutuality and holding) is that they may survive and even benefit from the co-constructing 'negotiations' that are part and parcel of informed consent. Compatible with this conclusion are reports by **Stoller (1988)** and **Searles (1979)** that they found it was easier to ask permission to write about more disturbed patients than about candidates and other patients within the neurotic register. At a metapsychological level, shared participation in clinical writing could be understood as offering reassuring 'holding' and the opportunity to identify with a good-enough object. At the same time, however, this hypothesis

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[1] Unfortunately, Stolorow and Atwood spoil the force of their argument by their simplistic misreading of Freud as having a vision of the mind as 'an impersonal machine' and the person as an 'isolated, monadic subject' (**1997**, p. 439) (cf. **Mills, 2005**).

[2] Lack of space makes a more complete study of all the available data on negotiations of consent or accidental discovery impossible. The reader is referred to the works of Gabbard, Galatzer-Levy, Kantrowitz and the many others cited elsewhere in this article.

necessarily narrows the applicability of Pizer's experience elsewhere, limiting it to publications about treatments in which supportive and corrective factors dominate. Neither of the cases referred to by Pizer appears to fall within the classic neurotic spectrum.

Pizer's second case, Rebecca, endorsed the writing because for her it meant 'knowing our work was linked to a professional community and to [Pizer's] own serious commitment to contributing to [his] field' (p. 258). Several times, she mentions regarding the writing as a guarantee of sanity and of safety; it was 'an essential symbolic indicator to her that I might be of sound mind and high serious-ness' (p. 257). Though it would not be surprising in the light of her chaotic and abusive family history, the reiterated reference to a 'proof' of safety has a defensive ring that might suggest that a paranoid layer still lay under her vastly improved relationship to the world. If the writing signified for Rebecca an appeal to a third party as guardian, then her consent may have acted to defend against an unmentalized fear of being reabused in the professional relationship with Pizer.

Pizer's patients are not alone is experiencing their involvement in the analyst's writing as a way of symbolically verifying or receiving sought-after valued parts of the analyst. A clinical vignette published by **Sloane (1993)** made his patient feel 'that her traumatic relationship to her mother was "witnessed to" and thereby vali-dated by my writing about her for a professional audience' [Sloane, 2001, personal communication). Crastnopol felt that her patient's involvement in her writing project culminated in 'some (perhaps illusory) formulations as to my reliability and integrity' (**1999**, p. 453). **Brenner (2005)** wrote of the 'documentation' of the clinical report as 'an important tool to combat [his patient's] skepticism and disbelief.'Access to their analysts' project of publication seemed in these instances to ferry psychological secondary gains for both parties, either in the form of reassuring mirroring or in the form of a reassuring perception of the analyst's inner world.

Some relational writers, however, rely on a different explanation for the positive action of informed consent. They turn to the notion of 'other' or 'third' that professional writing supposedly signifies. This hypothesis needs closer scrutiny both as to its own grounds and to distinguish it from the transindividual aspect of narrative referred to earlier. Writing certainly involves an address to another, to an outside audience. However, it would be useful to be more precise about what is meant meta-psychologically by the 'third' when it is called upon in this context. While writing engenders an imaginary and transitional space, it does not necessarily in itself serve a triangulating function because it is still under the power of either the analyst's or the patient's fantasy. The concept of the symbolic third introduced by Lacan **(Lemaire, 1977)** is specifically related to the recognition of 'difference' (sexual, generational) and of 'castration' (incompleteness, lack, the impossibility, and even the danger, of completely satisfying desire). The 'third' in this definition is linked to the paternal function as symbolic separator of mother and child. Thus for Lacan the triangulating function of the 'third' is not equivalent to being a good, reassuring therapist whose mind one can trust completely, but rather to accepting the limits of gratification possible in any one relationship. It is difficult to see how an imaginary and absent third (the imagined professional colleagues) can really serve to limit the

ego's captivation in the narcissistically mirroring of the dyadic relationship. On the other hand, professional consultation can provide triangulation because the consultant actually stands outside the relationship and is (at least partially) independent of the dyad's wishes.

A proposal for conceptualizing clinical writing as a 'third' has been put forward by Gerson who sees an analogy between one parent's interest in another and the analyst's interest in his professional community: 'These interests signify the presence of a third that both disrupts and contains the intensity and insularity of dyadic relating' (**2000**, p. 263). Gerson reasons that, since the 'triadic structure' is inherent in healthy development, it is possible to present the act of writing to the patient if it is introduced gradually and sensitively. Otherwise, he conjectures that 'we are in danger of making traumatic what could and should be a normal developmental process' (p. 263). I find the parallel between necessary developmental triangulation and informed consent about clinical writing somewhat misleading. The child has to adapt to a fact of life as a little Oedipus. Not only is the child usually spontaneously curious about the underlying nature of the parental relationship, *he needs to know about it*. It is, as **Aulagnier (2001)** would put it, part of his biographical patrimony. The child has the right to know so as to situate himself both with respect to the parents' desires for him and with respect to his place in society. The analyst's clinical presentation/publication introduces the analyst's imaginary address to an absent (and for the patient generally imaginary as well) third, who is not usually visible to the patient and who has no concrete status in the patient's life. The 'third' represented by the act of writing is not analogous to the real developmental father since it exists uniquely in the mind at the moment of writing and during negotiations of consent with the patient. It is an intrapsychic third projected outside. While it is true that '[u]ltimately, the patient needs to know himself or herself as existing in a mind with enough room to contain multiple needs from multiple sources' (Gerson, **2000**, p. **265**), can this be used as a rationale for forcing our career aspirations and theoretical attachments on to our patients? For the non-relational analyst, the developmental movement towards triangulation cannot be called upon as justification for analyst-initiated intrusion. If indeed the analyst decides that consulting the patient is the best thing, this act would be more solidly defended on other legitimate clinical grounds.

Gerson acknowledges that unconscious sexual fantasy can be triggered by patient involvement. He writes that:

> …premature and/or inadequately processed writing about the patient can become as difficult for the patient as would be an unmetabolized primal scene. In this case, writing can symbolize a stimulating but aggressive act that excludes the patient rather than an act that represents the integrative and inclusive possibilities afforded by a tempered movement through oedipal dynamics.
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> (**2000**, p. 264)

It is this very risk that worries many analysts. Even if we accepted Gerson's view that the analyst can control unconscious reactions with analytic skill and 'tempered movement', we would still be left with the quandary of a significant narrowing of the literature if clinical case studies were restricted to only those descriptions the patient has come to accept by the 'tempered movements' of the analyst. Nevertheless,

as will be seen below, the point he is making is an important one: how to think about avoiding and/or working though the activation of an unmetabolized primal scene when sharing clinical material with patients, a scene which can place the patient in the position of voyeur to the analyst's 'coupling' with others or in the very non-triangulated position of passionate partner in what amounts to 'sharing in the conception of a child' (Stein, **1988b**, p. **399**). An additional illustration of a non-triangulating fantasy was experienced by one of Lipton's patients who 'saw himself as a child being discussed in absentia by gods who would judge him and decide his fate' (**1991**, p. 971).

Another excellent clinical account of informed consent has been shared by **Crastnopol (1999)**. Crastnopol's argument for the therapeutic aspects of making the analyst's clinical writing part of the treatment process is remarkably similar to Gerson's, though it is handicapped by an inconsistency in her conceptualization of the third. While many analysts would support Green's statement that '[t]he three-party relationship is the matrix of the mind' (**2004**, p. 132), there are many different categories of 'thirds' and 'thirdnessess' in psychic life. Thirds and thirdnessess are presented in a variety of guises in Crastnopol's article: the analyst's 'professional self' (though why this subcategory of the analyst's strivings for narcissistic and material enhancement becomes a third is not explained); the analyst's 'operative discourse in therapy' as a triangulating third (though this makes the analyst's theory appear separate from the analyst's unconscious conflicts, an illusion Freud was the first to puncture in his writings about infantile sexual theories and which is also contradicted by the empirical research on analysts' belief systems she quotes); 'the analyst's professional domain' as a triangulating other (similarly, **Aron, 1999**, has written about 'psychoanalysis itself' as the third to analysts' dyadic relationships with their patients); the third as a containing function; the third as a 'removed "symbolic" vantage point'; the third as a simple numerical other; and the symbolic order as third, i.e. 'the pervasively structuring roles of language, culture, and semiotics in shaping individuals and interpersonal exchanges' (Crastnopol, **1999**, p. **460**).

Some of these terms are not 'thirds' in any intrapsychically structuring sense, whereas others 'triangulate' the psyche in significantly different ways. For example, any person outside the dyad is arithmetically a third but that does not mean that he is not also caught up in consecutive, dyadic, intersubjective dynamics with the other two parts of the triangle. This numerical third is not psychically determining in the same register as, for instance, the third proposed by Lacan in his concept of the symbolic order. The latter is a transcendent, impersonal order that has a determining and limiting power over all human beings. Gerson refers to this as 'a nonintersubjective form of thirdness' (**2004**, p. **77**). It is the conundrum of how to speak about confidentiality with regard to this unconscious, transindividual embeddedness of being that **Mauger (2003)** was trying to bring to our attention. As Lacan famously said,

> [I]t is the displacement of the signifier [that] determines the subjects in their acts, in their destiny … in their end and in their fate, their innate gifts and social acquisitions notwithstanding, without regard for character or sex, and … willingly or not, everything that might be considered the stuff of psychology, kit and caboodle, will follow the path of the signifier. (**1956**, p. 287)

In Crastnopol's **(1999)** otherwise thoughtful and well-researched account of an ongoing clinical writing project and her repeated exploration of it with the patient, this reader cannot help but be struck by the stunning absence of the sexual factor. A dream following the request for permission for publication is sensitively analyzed as evidence of the request as repetition of 'the patient's ongoing adult-life trauma of relating to an unusually narcissistic and misattuned mother' (p. **451**). Yet, though the dreamer depicts the analyst and herself as seated next to a bed with the professional papers of the former on it and which 'didn't feel like a therapy session—it felt more casual' (p. **449**), there is no mention of the erotic reference. Acknowledging that beds and bedrooms are quasiuniversal references to sexuality (because both members of the analytic dyad are irradiated intrapsychically by the symbolic order) might have allowed the analytic dyad to explore what would appear to be a separate layer of unconscious reaction: the unconscious sexual solicitation experienced by the patient in the analyst's philosophy that when patients 'partake in the professional side of the therapist's life … [it] enables them to be with me in a *fuller way*' (p. **449**, my italics). Thus, the initial 'strongly positive' reaction of the patient to the publication of a paper about her and the 'collaborative feel' of the dream could convey barely camouflaged eroticism stirred up by the implied invitation to intimacy with the analyst, as the kind of 'primal scene' mentioned by Gerson. If this intuition is valid, it conjures up the operation of a separate layer of transference contradicting Crastnopol's conclusion that '[t]he existence of a professional self apart from the analytic self acts to disrupt the illusion of a mother-child exclusive bond' (Crastnopol, **1999**, p. **465**). Far from it, the inclusion of the patient in the analyst's professional life may be enacting another exclusive bond and blurring the boundaries between the different 'selves' into which the author attempts to separate herself.

In his recent critique of relational psychoanalysis, Mills's objection to Ogden's **(2004)** postulation of an 'intersubjective third' that develops during the analytic process is close to my reservations of writing-as-a-third:

> To speak of a third subject or subjectivity that materializes out of the vapor of dialogical exchange is to introduce an almost impossible problematic of explaining how a noncorporeal entity could attain the status of being qua being, let alone how such entity could claim to have agentic determination over the dyad. (**2005**, p. 171)

More recently, Gerson has offered an alternative concept, that of the 'relational unconscious' which is 'not an object, a third, a triad, a field, or a space' (**2004**, p. **81**). Rather, the relational unconscious is a relationally embedded and structuring form of unconscious engagement. How and why traditional analysis in terms of transference and countertransference enmeshment is improved by the new notion of relational unconscious Gerson does not say, though he acknowledges that they are 'substantial and vexing questions' (p. **93**). What I find useful in both Ogden's and Gerson's work is their effort to find 'how best to work with the broadened concept of the unconscious that we inhabit with our analysands' (Gerson, **2004**, p. **93**). However, as to the notion of writing-as-a-third inspired by such intersubjective theorizing, I invite other readers to assess for themselves from the available published vignettes whether the dyadic interaction has been triangulated. For my part, the reported

clinical material makes more sense understood at the purely dyadic level where the writing symbolizes not a third but an enigmatic message from the analyst to the patient. I will return to this hypothesis later.

Since in Crastnopol's paper, additional recourse to the notion of the 'intersection' of separate selves (analytic, personal, and professional) informs her view of informed consent, the problematic nature of this conceptualization should be noted. When she writes that '[t]he analyst has a tendency to disavow or even dissociate her or his personal aspect and the extratherapeutic professional aspect while engaged in the therapeutic exchange' (**1999**, p. 467), one wonders what she understands the huge literature on countertransference to be all about. When she claims that 'our patients pick up snatches of our whole repertoire—personal and professional elements included' (p. 467), we need only cite **Racker (1957)**, considered the grand-father of modern approaches to countertransference, who would be the first in what is now a long line of mainstream analysts agreeing '[w]e know, to be sure, that real external qualities of the analytic situation in general and of the analyst in particular have important influence on the relationship of the analysand with the analyst' (**1956**, p. 310). Would it not be ironic if, having accepted in our countertransference understanding 'more fully the fact that we are still children and neurotics even when we are adults and analysts' (p. 307), we blur those boundaries further by treating our patients as 'partners' in our professional productions?

There is no doubt that reflection upon the impact on a particular patient of 'the professional discourses we introduce (whether preconsciously or unconsciously) to structure the treatment' (Crastnopol, **1999**, p. **462**) is an essential countertransference task. But, despite having referenced an empirical study **(Hamilton, 1996)** revealing widespread 'incoherence and internal contradiction of an analyst's professional convictions and practices' (p. 462), Crastnopol seems to feel that broaching with the patient the manner in which '[t]hese discourses influence how each of us sees our respective role' is enough to reduce the interpersonal 'disjunction' (p. 463). The rub is that the 'disjunction' is not only *interpersonal* but also *intrapsychic* in the case of the analyst's belief system: an internal disjunction does not evaporate merely because we can (sometimes) put our finger on it. Would that not be making the mistake of assuming that intellectual analysis of our personal paradoxes is enough to 'heal' them? While the different 'selves' activated in different social settings are more or less conscious entities that can theoretically 'intersect', it is difficult to imagine how we can expect the disjunction within the analyst to be easily grasped and integrated by the patient.

In his excellent overview of the disguise/consent debate, **Gabbard (2000b)** sums up that the use of clinical material for educational purposes or for publication presents the analyst with a conflict of interest between the patient's privacy and the educational and scientific needs of the field. Yet, as mentioned earlier, many examples in the literature illustrate that the loss of privacy, strictly speaking, is often not the flashpoint of patients' upheaval either when consent is requested or when they recognize themselves in a clinical vignette for which they were never asked to give permission. Thus, the dilemma is not just a two-sided jostling between privacy and scientific interests. It is a three-sided conflict that must include the

impact on treatment of the representation of themselves delivered to patients in their analyst's clinical account. The various intersubjective boomerang effects, positive and negative, reported in the literature (**Stoller, 1988**; **Aron, 2000**; **Scharff, 2000**; **Galatzer-Levy, 2003**; Goldberg, **2004a**, **2004b**; Kantrowitz, **2004a**, **2004b**, **2004c**, **2005a**, **2005b**, **2005c**) are iatrogenic disturbances of treatment caused by an act that can significantly modify patients' views of themselves and of their analysts. As Gabbard puts it, 'A further problem in deciding to obtain consent is that once the analyst has introduced the idea … it inevitably affects the subsequent course of the analysis' (**2000b**, p. **1081**). This fallout on the treatment relationship is an independent ethical consideration on an equal par with the binary pair of privacy and science. It is this 'further problem' which makes consent to psychoanalytic clinical writing so very different from standard medical practice where there is little ripple effect on the treatment plan per se of the requirement for consent.

Writing as a stimulus for analytic work

Some analysts, mainly those identifying themselves as relational in orientation, have come to view informed consent as not just a necessary ethical precaution but as a potential therapeutic benefit. In chapter 9 of her upcoming book, **Kantrowitz (in press)** summarizes interviews with nine relational analysts who use their papers about their patients as a tool for the treatment. The anecdotes she reports are precious reminders of how close to the bone the exercise of seeing oneself portrayed in writing by one's analyst can be but, additionally, that it is not a one-way street. The intimate self-revelation of disclosing a clinical account to a patient can be as exquisite and as excruciating for the analyst as it is for the patient. Kantrowitz notes 'the unconscious wish to communicate something to a patient is an additional motivation' for these analysts who acknowledge instances of having discovered through patient feedback the existence of a countertransference bias or limitation in the treatment previously hidden from themselves. The openness and gusto with which the negative commentary from patients was received and worked through cannot entirely distract attention away from the concern that these analysts may have been imprudent or naive to have proceeded without more careful thought about their motivations. As Kantrowitz comments, 'It is not always clear when the analyst is revealing these feelings for the sake of the patient and when it is for himself or herself.' She wonders whether 'the darker sides' of the analyst's conscious and unconscious motives are given enough consideration and—in minimizing the effect on patients of confrontation with parts of their personality and attitude as revealed in the writing—whether these analysts are not giving short shrift to the difference between implicit intuition on the part of the patient and explicit knowledge gained through reading.

A second general observation Kantrowitz draws from this sample is the frequency with which analysts justified involving the patient in the writing process because of the way it stirred up core transference conflicts and 'heightened the work' by providing a new vehicle for analyzing them. In her chapter, Kantrowitz provides a number of engaging accounts of stimulating and 'stimulated' analytic

work triggered by the analyst's insistence on sharing his for-publication clinical reflections. Insistence is not too strong a word since many of the sample were so convinced about the wisdom of patient participation that they did not easily take no for an answer. The corrective emotional outcome of the exchange with patients was explicitly sought by these clinicians: increased trust in the analyst, confrontation with the analyst's separateness, collaboration, bonding, emotional 'presence,' holding by a third, etc. For those who do not share the relational theoretical perspective, perhaps a more disquieting consequence of reading these interviews is the distinct impression that these analysts are often turning their patients into supervisors. For reasons unclear to the reader, these analysts seem to short-circuit the free associative space by precipitating patients into a crisis of self-confrontation in being asked to review written clinical material about them. As Kantrowitz asks, 'A further question is why this new technique is needed for the more highly functioning kind of analytic patient?'Why indeed does the analyst need to resort to the indirect route of showing the patient something written about him, rather than trying to bring about insight by directly addressing these matters in sessions? Until the reservation about adequate technique is laid to rest, i.e. that informed consent might be being used by some analysts to bypass inhibitions about dealing directly with certain transference knots, I cannot share Kantrowitz's conclusion (despite a number of misgivings of her own) that 'relational analysts have pioneered a new way to think about the introduction of the analyst's writing into analytic work.' Her suggestion that written material may proffer 'a kind of transitional object' is an interesting one, but it cannot and should not 'create an object constancy for these patients that the real person of the analyst does not.' If this is what the written account becomes, it loses the essence of transitionality as a state of simultaneous being and not being and as a creation of the baby/patient rather than of the mother/analyst.

The specificity of psychoanalytic clinical reporting

The reactualization of intersubjective developmental conflicts in the transference and countertransference that is permitted by the analytic setting becomes, as we know, the most valuable tool for its mentalization and working through. This fundamental fact of psychoanalytic technique distinguishes the ontological (being) status of clinical material compared to the data found in medicine or other connected fields. In an overview article, Mayer concludes that there is a consensus among analysts as to 'the *relational, intersubjective and subjective nature* of a psychoanalytic clinical fact … [C]linical facts … simply do not exist as discernable *facts* outside the subjectivity and intersubjectivity of the analytic relationship' (**1996**, p. 710, original italics).

It follows from Mayer's overview of contemporary thinking that whatever is explicitly announced by the analyst with respect to the patient's subjective or unconscious state conveys an implicit complementary subjective or unconscious position in the analyst. Smith writes, 'All interpretations, if examined carefully enough, reveal themselves … as compromised expressions of the analyst's conflicts' (**1997**, p. **27**). As Michels puts it:

> Writing a case history, or for that matter planning to write one or even thinking about it, is at least in part a countertransference theme or enactment. This means that it may offer an insight into the analyst and the analysis by revealing how the meaning of the analysis is incorporated into the analyst's personal and professional psychic life. (**2000**, p. 372)

Tuckett goes even further, pointing out that:

> …the analyst's choice of material provides information about the analytic situation and about the patient's pathology and transference *of which the presenting analyst may not be fully aware*: rather than being a weakness, as it would be from a strictly historical approach to truth, could not this feature of the analyst's narrative be considered the quintessential aspect of a psychoanalytic clinical presentation? … [I]n his attempt to communicate the analyst says more than he consciously knows. (**1993**, p. **1184**, original italics)

He adds that 'the analyst presents a process of which he is a vital part; viewed in this way, the presentation, including the selection, is part of the material offered to the audience' (p. **1184**). Part of what the analyst may not be fully aware of is how his unconscious investment in the patient comes to be transferred in and through the act and content of writing. Professional communication is often an alternative avenue for working through by the analyst as well as a request for collegial input into dynamics inadequately mastered or into treatment failures. It is worth noting in this regard that a few analysts in Kantrowitz's sample **(2004a)** spoke of writing as a kind of self-supervision while **Gabbard (2000a)** refers to the need many who publish have to overcome complex and difficult countertransference reactions.

Naturally, we cannot know in advance that which in the unconscious has escaped our control and remains misunderstood in our effort to theorize. Yet, it is precisely the movement to include and understand our participation in the relationship, with its risk of revealing an incompletely apprehended kernel of ourselves, which marks the originality of psychoanalytic communications oral and written. Rolland agrees:

> [in a clinical presentation] I must expose at the same time as my conscious reflections, that emotional part, that repressed remainder of experience which is also possibly the most lively aspect of my inspiration and which I confide to your ear and to your interpretation. My talk requires your floating attention which authorizes you to hear the repressed and to help bring forth its meaning. (**1998**, p. 3)

This aspect of psychoanalytic clinical sharing separates it, radically, from other types of scientific communication, such as the psychiatric history or the psychological case report. There is no way of exporting information about the patient without conveying something about the dynamics of the dyad and something unconscious about the analyst's investment in their work. And it would be difficult to justify designating a clinical report as 'analytic' if it did not bring something of as yet unmastered intersubjectivity with it. Consequently, can we honestly in psychoanalytic writing allocate copyrights without splitting impossible hairs **(Levin, 2003)**?

The impact on the patient of the exposure to analyst-as-author

The series of reflections on the impact of clinical writing on patients introduced so far allows, I believe, the enunciation of a master hypothesis for framing our

metapsychological understanding of this impact. The unavoidably subjective portion to analytic reporting is bound to have emotional reverberations for patients reading about themselves regardless of official theoretical orientation. Based upon my perusal of anecdotes in the literature pertaining to the negative reactions of patients who believe they have recognized themselves in published articles, what upsets patients is not exclusively, nor even necessarily, what they read about them-selves, but what they assess or intuit—directly or indirectly through the material presented—of their analyst's internal life.

As stressed earlier, written analytic formulations about a particular patient, or category of patients, are likely to contain some residual, and incompletely metabolized, elements of the analyst's unconscious desire and fantasy. It is this 'leftover'—small though it might be—that might distress and puzzle patients who, in becoming aware of the formulation, cannot help wondering why the analyst has chosen to write about or present 'their' case. Why is he interested in this particular aspect of my problems? Has he been thinking of this presentation to others when I thought we were alone together and I the exclusive focus of his attention? A 'why me?' and 'why now?' and 'why with them?' questioning may set in motion a significant 'afterwardness'[3] reappraisal of identity and relationship to the analyst.

My guess is that requests for consent, or accidental self-recognition when consent has not been discussed, end up activating a new and surplus mystery about the analyst's investment in the patient. Why does he need to communicate about me to outsiders? What is he going to talk about or write about? What is it that is troubling, difficult, exciting, interesting, or weird about me that he wants/needs to share with another? A comment by one patient after reading a chapter about herself illustrates this well: 'I didn't see what you wrote as so much about me as about *you*. It showed me something about how you thought about your work, and it helped me feel that more was possible' (Pizer, **2000**, p. 257, original italics). When analysts justify speaking to patients about their professional writing by appealing to the salutary effect it has in allowing patients to 'feel confident that they exist securely in their therapist's mind' (Gerson, **2000**, p. **263**), I think they are inadvertently expressing the same idea, i.e. that, in perusing their analysts' work, patients are searching for, and finding out, something about the analyst's mind. From this perspective, disguise is not the issue: *it is what they learn about us in our thinking about them*. In **Laplanchean (1999)** terms, whenever patients come across references to themselves in their analysts' written or oral communications to peers, they are forced to deal with new 'enigmatic signifiers' revealed in our imagined 'couplings' with third parties unknown to them. I frankly do not think lawyers can help us with this conundrum.

One might object that I am overvaluing the potentially traumatic effect on patients based on two questionable assumptions: 1) that patients do not already know this data about our relationships with them and 2) that we have not already worked over the various intersubjective meanings of the exchanges we are divulging (Rosemarie

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[3] Jean Laplanche (see **Fletcher, 1999**) proposes the neologism 'afterwardness' as a better translation of Freud's notion of *Nachträglichkeit* than the term 'deferred action' found in the *Standard Edition*.

Krausz, 2002, personal communication). It could be argued that, on the one hand, I have fallen back into the illusion of being able to offer analysands a blank screen. And, on the other hand, it makes sense that reading a clinical description proposing constructions and interpretations that have been a part of his treatment would be less troubling to the patient than unexplored emotional territory. I recognize the value of making these two qualifying statements, though they do not by any means efface the considerations I have raised. 'Knowing' something unconsciously or even preconsciously and intuitively is not the same thing as 'knowing' it explicitly and to pretend otherwise disregards the scientific utility of making these cognitive distinctions (as mentioned earlier, Kantrowitz makes a similar remark in her forthcoming book). If these distinctions were not worth making, there would be no discomfort with widespread nudity since we all 'know' about the sexual differences. As to the second point, I doubt that we would want to restrict analytic scientific communication exclusively to clinical dynamics well understood and metabolized by both parties.

My hypothesis leads to a new basis for ethical inquiry: what ethical consequence in our professional use of clinical material derives from the subjective quotient in analytic 'fact' sharing, a sharing that reveals something of the analyst as well as of the patient? Since the shadow of the unconscious thing upon the analytic communication is not one controllable by the analyst, I would put forward consultation in interanalytic space as the wisest precaution in deciding on disguise or consent. It is assumed that the interlocutor would be an analytic one, prepared to attend beyond the words to unmetabolized countertransference derivatives. Although consultation cannot be a perfect solution, it can be expected to reduce the analyst's blind spots concerning the nature of his use, or understanding, of the clinical material and the potential impact on the patient of either consent or accidental discovery. A number of authors (**Lipton, 1991**; **Galatzer-Levy, 2003**; **Kantrowitz, 2004a**, **in press**) have concluded that analysts cannot always anticipate the risk of negative patient feedback caused by reading clinical material. In this recommendation, I am adding another reason for the regular consultation in our field encouraged by **Gabbard (2000a)**. In opposition to the notion of writing as a triangulating third for the patient, I would counter with the idea of writing as ineluctably transmitting an unconscious countertransference message, the enigma of which the analyst may reduce with the aid of the *thirdness afforded by a third analytic ear*.

The mediating factors of theoretical orientation and analyst's guilt

One can surmise from the growing literature that informed consent frequently draws the therapeutic couple willy-nilly into more interaction in order to work through the transference aftermath. In other words, informed consent requires more disclosure from the analyst. Analytic neutrality might even be undesirable under these circumstances since it would stand in the way of the analyst's ability to repair the disruption he has himself caused to the relationship by bringing up his wish to use the patient's material outside of the consulting room. Theoretical commitment and preferred technique may be critical factors in the process. Some theoretical paradigms not

only accommodate more comfortably the intersubjective repercussions of informed consent but also actively seek it. Thus, for some analysts the procedure will be more ego-syntonic and, regardless of how convincing their rationale, it is likely (though of course not guaranteed) that an analyst less conflicted about asking will make for a patient less conflicted about accepting. Kantrowitz's (**2005c**, **in press**) research shows that analysts with an intersubjective, co-constructivist orientation feel more at home discussing their planned use of clinical material with their patients. The larger place within their theoretical framework for positive uses of countertransference exposure might conceivably communicate less ambivalence about asking the patient than would a more classical clinician who experiences more conflict about it. Analyst guilt about publishing clinical material is an undertheorized but intense and widespread affect. Rather like Freud who suggested that analysts need to talk about sexual matters without shame or prudery, Gerson takes the position that

> …the benefit or harm of [the fact that the analyst's personal and professional needs are at odds with those of the patient] resides not in its factuality but rather in the analyst's readiness to acknowledge this in a forthright and nondefensive manner with the patient. (**2000**, p. 265)

Certainly, the analyst's openness will soften the blow of the intrusion, and the contamination of the analyst's guilt, especially in the short run. But in the light of the reservations raised in this article, and what Messler Davies and others have recognized as the inherent 'unpredictability of clinical events' (**2000**, p. 225), in the long term, can the analyst alone with his patient effectively handle, foresee, or forestall other long-term afterwardnesses?

In summing up his most recent reflections on consent and clinical reporting, Goldberg draws on Derrida's discussion on ethical decisions in which the latter affirms that every such decision 'requires confrontation of its essential, irreducible undecidability' (**2004a**, p. 521). Indeed, this principle of 'indeterminacy' goes back many centuries in legal history. The legal scholar Morissette defined this principle as the necessity of:

> …delivering a value judgment on insoluble questions, i.e., questions that are ontologically refractory to logico-deductive reasoning [from within the contemporary body of legislative, judicial, and regulatory articles]. If an issue reaches the Supreme Court … it is precisely because there is no a priori judgment that can be rendered before the very value judgment that that decision-making body delivers. (**2000** p. 597)

Morissette maintained that due respect for this indeterminacy with respect to certain problems should encourage judges to 'show self-restraint, to practise epistomological humility and to be forever aware of the precariousness of their legitimacy' (p. 591).

Though it may not be comforting to be reminded, the courts and psychoanalysis must part company at this point. Whereas what matters, ultimately, to the law is that a controversy be brought to an end with a final and authoritative answer **(Morissette, 2000)**, I agree with Goldberg (**2005**, **2000a**) that psychoanalysis may have to continue living with its impossible decisions and their attendant risks. We might have to go even further: it may be part of the legacy of the transitional space

we cherish in the consulting room that not only may we never be able to find a ‘final’ answer to the consent conundrum, but we may even wish indeterminacy to endure as long as possible.

Conclusion

The unique character of psychoanalytic reporting, which can, and to some extent must, carry with it a portion of inherently personal, and perhaps unconscious, elements related to the analyst's choice of, and interpretation of, clinical material, requires the pondering of new clinical considerations when there is a risk that patients may come across references to themselves in published clinical accounts. The relational, intersubjective, and subjective nature of psychoanalytic ‘facts’ makes legal definitions of ownership inapplicable, at least in the clinical situation. Our ethical and clinical concerns are best guided by the analytic exploration of the intrapsychic and intersubjective impact of informed consent on individual analytic dyads. Notions of privacy, validation, dyadic co-construction, or containment by a third as rationales for involving patients in professional writing fail to encompass the transindividual and external sources of human identity and the ineradicable lack of unity in the unconscious. It is suggested instead that the potential impact on patients of consciously discovering, or of unconsciously discerning, new parts of their analyst's personality and internal life needs to be accorded more thought. The enigma of the analyst's need to share his case with colleagues cannot fail at some level to have a somewhat seductive or alienating influence, as a new enigma about the analyst's investment in the relationship, potentially precipitating a rear-rangement in the patient's self-image, as he re-evaluates his self in the light of the imagined message conveyed in the analytic publication about his place as object for the analyst-as-writer. To truly triangulate the clinical reporting process, it is wisest to consult with a colleague regarding the analyst's version of the ‘co-thinking’ **(Widlöcher, 2004)** accomplished in a treatment to assess whether discussing this material with the patient is the best clinical decision under the circumstances.

Translations of Summary

Weitere Gedanken über die Beeinflussung derPatienten durch Fallberichte. Auch wenn es wahrschein-lich nie möglich sein wird, universelle Leitlinien für die Einholung des Einverständnisses des Patienten zu fixieren, dass der Analytiker klinisches Material außerhalb des Behandlungssettings verwendet, formuliert dieser Beitrag Überlegungen, die die bereits vorhandene einschlägige Literatur ergänzen können. Ungenau angewandte Richtlinien für den Einwilligungsprozess würden die Verzerrungen, die in unserer klinischen Literatur aufgrund der selbstauferlegten Zurückhaltung der Autoren bestehen, weiter verstärken. Darüber hinaus können die mächtigen irrationalen Kräfte, die durch eine Zustimmung in der Dyade mobilisiert werden, nicht ohne weiteres von den traditionell angewandten juristischen Kategorien “gehalten” werden. Wir benötigen metapsychologische Formulierungen der intrapsychischen und intersubjektiven Auswirkungen, die eine Beteiligung des Patienten am Prozess des Schreibens über individuelle analytische Dyaden mit sich bringt. Überlegungen zum Schutz der Privatsphäre, zur Validierung, zur dyadischen Kokonstruktion oder zum Schreiben als Containment durch ein Drittes können als Rechtfertigung einer Einverständniserklärung den trans-individuellen und äußeren Quellen der menschlichen Identität und dem unabänderlichen Fehlen von Einheit im Unbewussten nicht Rechnung tragen. Trotzdem könnten theoretische Affinität und bevorzugte Technik Faktoren darstellen, die positive Ergebnisse des Einwilligungsprozesses vermitteln. Bestimmte Paradigmen werden dem intersubjektiven Widerhall der Einwilligung nicht nur besser gerecht, sondern suchen aktiv danach. Als Alternative oder ergänzender Blickwinkel soll die These dienen, dass die klinische

Weiterung von Anonymisierung oder Einwilligung nicht ausschließlich und nicht einmal zwangsläufig das ist, was Patienten über sich selbst lesen, sondern was sie—anhand des beschriebenen Materials direkt oder indirekt—an unbewussten Strebungen des Analytikers wahrnehmen oder erahnen. Um den klinischen Bericht wirklich zu triangulieren, ist es am klügsten, sich an das dritte Ohr eines Kollegen zu wenden, damit dieser die potentiellen Auswirkungen dessen beurteilt, was der Analytiker im Prozess des Schreibens und der Einwilligung unbewusst vermittelt.

Nuevas reflexiones sobre el impacto que las publicaciones clínicas pueden tener sobre los pacientes. Aunque es improbable que alguna vez se establezcan pautas universales para el consentimiento de los pacientes para el uso del material clínico por parte del analista fuera del encuadre terapéutico, este artículo ofrece algunas reflexiones complementarias en relación a las ya disponibles en nuestra literatura. Si se aplicaran de manera generalizada determinadas pautas sobre el consentimiento, éstas aumentarían la distorsión que existe ya en nuestra literatura clínica por las restricciones que se imponen en cualquier caso por los propios autores. Además las potentes fuerzas irracionales que se movilizan en la relación analítica por el consentimiento a publicar el material no serían fácilmente contenibles en las categorías legales tradicionales. Se hacen indispensables entonces formulaciones metapsicológicas sobre el impacto intrapsíquico e intersubjetivo que la participación del paciente en la escritura del caso clínico ejerce sobre cada pareja analítica específica. Las nociones de protección de la privacidad, validación, co-construcción diádica, o escritura entendida como un "tercero" contenedor con las cuales se tiende a explicar la necesidad de la información del consentimiento, no tienen en cuenta del las fuentes externas y transindividuales de la identidad humana y de la profunda falta de unidad en el inconsciente. Sin embargo, las afinidades teóricas y técnicas podrían constituir factores de mediación y podrían producir resultados positivos en el proceso de consentimiento. Algunos paradigmas no solo se adaptan más fácilmente sino que desarrollan también las repercusiones intersubjetivas de la información del consentimiento. Se ofrece como punto de vista alternativo complementario, la hipótesis de que las consecuencias clínicas tanto de la deformación del material como del consentimiento no son ni exclusivamente ni necesariamente debidas a lo que los pacientes leen de lo que se ha escrito sobre ellos, sino a lo que deducen o intuyen- directa o indirectamente del material clínico- de los esfuerzos inconscientes de su analista. Con el fin de obtener una triangulación auténtica del proyecto de escribir el material clínico es deseable la introducción de un tercer elemento: la "escucha" por parte de un colega que acepte evaluar el impacto potencial sobre los pacientes de lo que el analista podría comunicar inconscientemente en el proceso de la escritura y del consentimiento.

Nouvelles réflexions sur l'impact des écrits cliniques sur des patients. Même s'il paraît peu probable que des recommandations universelles pourraient être instituées un jour sur le consentement du patient à l'utilisation du matériel clinique par l'analyste en dehors du cadre du traitement, cet article propose quelques réflexions supplémentaires par rapport à celles déjà disponibles dans la littérature. Si des recommandations sur le consentement étaient largement appliquées, elles augmenteraient la distorsion qui existe déjà dans notre littérature clinique en raison des restrictions que s'imposent de toute façon les auteurs euxmêmes. De plus, les forces irrationnelles puissantes mobilisées par le consentement au sein de la dyade ne sont pas facilement « maîtrisées » par les notions légales traditionnelles applicables. Des formulations métapsychologiques sont nécessaires sur l'impact intrapsychique et intersubjectif de la participation du patient dans le processus de l'écriture sur des dyades analytiques individuelles. Les notions de protection de la vie privée, de validation, de co-construction dyadique, d'écriture-comme-contenant par un Tiers, utilisées en tant que formalisations du consentement éclairé, échouent à inclure les sources transindivi-duelles et externes de l'identité humaine et le manque inexpugnable d'unité de l'inconscient. Cependant, l'affinité théorique et la préférences de technique peuvent être des facteurs de médiation dans les évolutions positives du processus de consentement. Certains paradigmes, non seulement s'adaptent plus aisément, mais recherchent activement les répercussions intersubjectives du consentement éclairé. Notre hypothèse, proposée comme une alternative ou comme un point de vue complémentaire, est que les ramifications cliniques tant du déguisement que du

consentement ne se réduisent pas exclusivement, ni même nécessairement, à ce que les patients lisent les concernant. Elles sont aussi ce que les patients évaluent ou dévinent - directement ou indirectement à travers le matériel présenté - des efforts inconscients de leur analyste. Pour trianguler réellement le projet de rapporter un cas clinique, il est plus sage de consulter l'oreille tierce d'un collègue, afin évaluer l'impact potentiel, sur les patients, de ce qui est susceptible d'être transmis de façon inconsciente par l'analyste dans le processus de l'écriture et du consentement.

Altre riflessioni sull'impatto che le pubblicazioni cliniche possono avere sui pazienti. Questo articolo propone alcune ulteriori rifessioni a quelle giá presenti in letteratura sul consenso dei pazienti all'uso di materiale clinico al di fuori del setting analitico, sebbene sia ancora lontanamente realizzabile l'idea di una

normalizzazione universale istituzionale. Questa infatti non farebbe che aumentare il livello di distorsione giá esistente nelle nostre pubblicazioni, dovuto alle restrizioni che gli autori stessi si impongono. Inoltre, le potenti forze irrazionali messe in gioco nel rapporto analitico dal processo consensuale non sarebbero facilmente contenibili nelle tradizionali categorie legali. Si rivelano allora necessarie formulazioni metapsicologiche dell'impatto intrapsichico e intersoggettivo che la partecipazione del paziente alla scrittura del caso clinico esercita su ogni specifica diade analitica. Nozioni come protezione della privacy, validazione, co-costruzione diadica, o 'scrittura come terzo elemento di contenimento', con le quali si tende a spiegare la necessità del consenso informato, non tengono conto delle fonti esterne e transindividuali dell'identitá umana e della profonda mancanza di unitá nell'inconscio. Ciò nonostante, affinità teoriche e tecniche potrebbero costituire fattori di mediazione e potrebbero produrre esiti positivi del processo consensuale. Alcuni paradigmi, non solo tengono conto in maniera piú consona delle ripercussioni intersoggettive del consenso informato, ma svolgono anche una ricerca attiva sulle stesse. Viene offerta come punto di vista alternativo o complementare, l'ipotesi che le conseguenze cliniche sia del mascheramento che del consenso non siano né esclusivamente né necessariamente dovute a ciò che i pazienti leggono sia stato scritto su di loro, ma a ciò che deducono o intuiscono - direttamente o indirettamente dal materiale clinico - sui travagli inconsci dell'analista. Al fine di ottenere una reale triangolazione del progetto di scrittura clinica, è auspicabile l'introduzione di un terzo elemento: l'ascolto' da parte di un collega che consenta di valutare l'impatto potenziale sui pazienti di ciò che l'analista protrebbe comunicare inconsciamente nel corso del processo consensuale e della scrittura del caso.

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